TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Fondren Orthopedic

Respondent Name
Hartford Fire Insurance Co

MFDR Tracking Number
M4-16-1797-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The surgeons did bill with the 22 modifier to indicate that the services they had provided were greater than that usually required for the listed procedure… The physician has noted in the operative report that the modifier 22 was billed due to this being an extensive and complex procedure…"

Amount in Dispute: $592.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found the following: Original bill received 12/14/15 and paid per fee at $1541.85. Recon received 2/1/16 and denied as originally processed in error. Per review of medical fee dispute an additional recommended amount of 154.19 was paid for modifier 22 on 3/15/16. Modifier 22 paid at 10%."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2015	27524/22	$592.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services.

3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 245 – The service provided was greater than that usually required for the listed procedure
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 4063 – Reimbursement is based on the physician fee schedule when a professional service was performed in the facility setting
   - W3 – Additional payment made on appeal/reconsideration
   - 1115 – We find the original review to be accurate and are unable to recommend properly the first time
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommended further payment to be made for the above noted procedure

Issues

1. Did the requestor's documentation support billing modifier 22?
2. What is the rule applicable to reimbursement?
3. Did the requestor support position that additional reimbursement is due for code 23472/22 –RT, per 28 Texas Administrative Code §134.1?

Findings

1. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   On the disputed date of service, the requestor billed CPT codes 23472/22, LT. The services in dispute are: 23472/22, RT.
   The requestor appended modifiers:
   - 27524 - Open treatment of patellar fracture, with internal fixation and/or partial or complete patellectomy and soft tissue repair
   - "22-Increased Procedural Services" defined as "When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required)."
   - "LT – right side."

   The requestor noted in the Operative Report that "this was made more difficult because of comminuted nature requiring more fixation and long deter to put the patella together."

   The Division finds that the requestor's documentation supports the use of modifier 22.

2. The requestor billed $2,775.00 for code 23472/22, RT. The respondent paid $1,696.04. The requestor is seeking additional reimbursement of $592.66 for the additional services billed with modifier 22.
   Per 28 Texas Administrative Code §134.203(c)(1)states,
   To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date

of service yearly conversion factor). For Surgery when performed in a facility setting, the established conversion factor to be applied is (year of service annual conversion factor).

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) x Participating Amount = Maximum Allowable Reimbursement (MAR).
Place of Service is 22 – Outpatient Hospital
The 2015 DWC conversion factor for this service is $70.54.
The Medicare conversion factor is $35.9335
Review of Box 32 on the CMS-1500 the services were rendered in zip code 77339, which is located in Kingwood, Texas; therefore, the Medicare participating amount is based on locality "Rest of Texas".
Medicare Participating amount for code 27524 is $739.79.
Using the above formula, the Division finds the following: (70.54 / 35.9335) x $739.79 = MAR of $1,452.26. Based upon the submitted explanation of benefits, the respondent paid $1,541.85 with a payment processed on December 30, 2015 and an additional payment processed on March 15, 2016 in the amount of $154.19 for a total payment of $1,696.04. Pursuant to Rule 134.203(c)(1) the maximum allowable reimbursement has been paid for the disputed code. Discussion of additional reimbursement based on the "-22" modifier is discussed below.

3. The requestor contends that additional reimbursement of $592.66 is due because of the increased services required and supported by modifier 22.

   The *Medicare Claims Processing Manual* Chapter 12 §20.4.6 entitled *Payment Due to Unusual Circumstances (Modifier "-22" and "-52").* Rev 1, 10-01-03, B3-15028, states that "The fees for services represent the average work effort and practice expenses required to provided a service. For any given procedure code, there could typically be a range of work effort or practice expense required to provided the service. Thus, carriers may increase or decrease the payment for a service only under very unusual circumstances based upon review of medical records and other documentation.

   The *Medicare Claims Processing Manual* Chapter 12 §40.2.A.10 entitled *Unusual Circumstances,* Rev. 1, 10-01-03, B3-4822, defines "Surgeries for which services performed are significantly greater than usually required may be billed with the '-22' modifier added to the CPT code for the procedure."…"The biller must provide:

   - A concise statement about how the service differs from the usual; and
   - An operative report with the claim

   The *Medicare Claims Processing Manual* Chapter 12 §40.4.A. entitled *Fragmented Billing of Services Included in the Global Package,* Rev.1, 10-01-03, B3-4824, B3-4824, B3-7100-7120.7, provides in relevant part, that "Claims for surgeries billed with a "-22" or "-52_ modifier, are priced by individual consideration if the statement and documentation require by §40.2.A.10 are included."

   When the provider has billed for services that Medicare does not assign a relative value unit or payment, 28 Texas Administrative Code §134.203(f) states, "For products and services for which no relative value unit or payment has been assigned by Medicare, Texas Medicaid as set forth in §134.203(d) or §134.204(f) of this title, or the Division, reimbursement shall be provided in accordance with §134.1 of this title (relating to Medical Reimbursement)."

   28 Texas Administrative Code §133.307(c)(2)(O), requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:

- The requestor does not discuss or demonstrate how additional reimbursement of $592.66 for code 27524/22, LT is a fair and reasonable reimbursement.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not discuss or support that the proposed methodology would ensure that similar procedures provided in similar circumstances receive similar reimbursement.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

Authorized Signature

		March 21, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.